



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4812 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

DOWNTOWN PERFORMANCE MEDICAL CENTER  
3033 FANNIN STREET  
HOUSTON TX 77004

#### **Respondent Name**

TRAVELERS INDEMNITY CO

#### **Carrier's Austin Representative**

Box Number 05

#### **MFDR Tracking Number**

M4-11-1835-01

#### **MFDR Date Received**

February 3, 2011

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We are requesting your assistance in processing the medical bills related to the above-mentioned patient for DOS 5/10/2010. Payment was denied for the following reason: > W\$ - NO additional reimbursement allowed after review of appeal/reconsideration. We obtained pre-authorization for this service prior to rendering services for this patient. Also services post and prior this DOS have been paid in full per Fee Guidelines."

**Amount in Dispute:** \$223.01

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Provider's Request for Medical Fee Dispute Resolution involves reimbursement for physical therapy services. The Provider received preauthorization for six sessions of physical therapy. After beginning services, the Provider submitted billing for multiple dates of service, including the date in dispute here. The Carrier reviewed the billing, and reimbursed all dates of service except the date of service at issue in this Request for Medical Fee Dispute Resolution. Reimbursement for this date of service was denied as the Provider's 95-day deadline to timely submit the billing expired prior to the submission. The Provider requested reconsideration, but provided no documentation to support timely submission. Consequently, the Carrier upheld the denial."

**Response Submitted by:** Travelers

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2010	97110-GP, G0283-GP and 97140-GP	\$223.01	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated September 1, 2010

- 29 – The time limit for filing has expired. Per Texas Labor Code 480.027, bills must be sent to the carrier on a timely basis, within 95 days from the dates of service.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Explanation of benefits dated December 14, 2010

- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

## **Issues**

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

## **Findings**

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95<sup>th</sup> day after the date the services are provided."

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

2. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

Review of the submitted information finds no documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

_____	_____	October 17, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**